MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09142

93d

Reg. Dist. No. 202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Kent
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Kent
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William C. Brown William C. Brown

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Ida Anderson Brown
6.(c) If alive, give age 74 years
7. Birth date of deceased (mo., day, yr.) Nov. 5, 1870

8. AGE: Years 76 | Months 11 | Days 10 | If less than one day: hrs. min.

9. Birthplace Laurinsville Pa. (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business General Labor

FATHER
12. Name Brown
13. Birthplace Penn

MOTHER
14. Maiden name Mary Dehart
15. Birthplace Penn

16. Informant Mrs. Cora S. Hunt Address Chestertown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 24, 1947 (month) (day) (year)
Cemetery or crematory Chester Cemetery
Location Chestertown, Maryland
18. Funeral director J. Willis Wells
Address Chestertown, Maryland

19 Oct. 21, 1947 (Date rec'd by registrar) Clara S. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1947 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 17 1947 to Oct. 24 1947 and that I last saw h... alive on Oct. 20 1947

Immediate cause of death Myocardosis — Duration 7 days
Due to Arteriosclerosis — Duration Yrs.
Due to — Duration Yrs.
Other conditions — Duration Yrs.
(Include pregnancy within 3 months of death)

Major findings of operation None Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? No (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury No injured at work?

23. SIGNATURE Paul Barnes M.D. M. D. or other
Address Chestertown Md. Date signed 10/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

09143

CERTIFICATE OF DEATH

Reg. Dist. No. 204

1. PLACE OF DEATH:
County: Melitota (West Chestertown Rd)
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: (West)
City or town: Melitota Chestertown Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Wesley Cottman

3.(b) Social Security Number:

4. Sex: Male | 5. Color or race: Col | 6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Leonora Lester Cottman

(c) If alive, give age: Died years

7. Birth date of deceased (mo., day, yr.): 1883

8. AGE: Years: 64 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: West Chester Penn (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farming Industry

FATHER
12. Name: John R Cottman
13. Birthplace: Kent Co Md

MOTHER
14. Maiden name: Georgiana Robinson
15. Birthplace: Pa

16. Informant: Henry Cottman
Address: Chestertown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 26 1947 (month) (day) (year)
Cemetery or crematory: Melitota
Location: Melitota Chestertown 2 Md

18. Funeral director: Asbury Henry
Address: Chestertown Md

19. Oct 26 1947 (Date rec'd by registrar) F. H. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 23 1947 at 7:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Did not attend Investigate Death 19 10 and that I last saw deceased alive on 19 10

Immediate cause of death: Myocarditis Duration: Several yrs

Due to: Arteriosclerosis Duration: Yrs

Due to: Duration:

Other conditions: Duration: Yrs

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

How injury occurred: Death from Natural Causes. Chestertown Md

23. SIGNATURE: M. D. or other

Address: Chestertown Md Date signed: Oct 27 47

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

49a

09144

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16
Hospital, institution, or street address where death occurred: Kent and Queen Annes Hosp
How long in hospital or institution? 16

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Rural Rock Hall
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Near Rock Hall
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lillian Gale

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Do not know birthday 1876

8. AGE: Years: about 71 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Rock Hall, Kent, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: John L. Gale
13. Birthplace: Maryland

MOTHER 14. Maiden name: Annie Judefind
15. Birthplace: Baltimore, Maryland

16. Informant: Hospital Records
Address: Chestertown

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 12-47 (month) (day) (year)
Cemetery or crematory: Wesley Chapel
Location: Rock Hall Md

16. Funeral director: Edgar L Lane
Address: Church Hill Md

19. Oct. 12, 1947 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10 1947, at 10 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-24 1947, to 10-10 1947
and that I last saw her alive on 10-10 1947

Immediate cause of death	DURATION
Carcinomatosis, generalized abdominal	5 months
Due to: Carcinoma left ovary	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Generalized abdominal carcinomatosis Date of op. 9-26-47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. C. Dick, M.D. (M. D. or other)
Address: Chestertown, Md Date signed: 10-10-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09145

170c

CERTIFICATE OF DEATH

Reg. Diat. No. 205

1. PLACE OF DEATH:

County: Kent

City or town: Near Massey

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Temporary

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Near Massey

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edward Arthur Guessford

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ******

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 30.1924

8. AGE: Years	Months	Days	If less than one day
23	5	25	hrs. min.

9. Birthplace: Delaware (town, county, and state)

10. Usual occupation: Trucker

11. Industry or business: Farming

FATHER — 12. Name: Charles Guessford

FATHER — 13. Birthplace: Ddlaware

MOTHER — 14. Maiden name: Daisy Heriven

MOTHER — 15. Birthplace: Delaware

16. Informant: Charles Guessford,

Address: Clayton Del.

17. (Burial, cremation, or removal. Which?) Date thereof 10-21-47 (month) (day) (year)

Cemetery or crematory: Townsend

Location: Townsend Delaware

18. Funeral director: G. Luke Daniels

Address: Middletown Delaware

19. Oct. 22 19 47 (Date rec'd by registrar) Edward Fellows Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 18. 19 47 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Did not attend Investigated death 19 to 19 and that I last saw h alive on signed certificate s Deputy Med. Exam Kent Co Md 19

Immediate cause of death	DURATION
Fracture Skull	
Due to: Multiple fractures arm and leg	Immediate
Due to: Auto Accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of

Where did injury occur? near Massey (City or town) Kent Co Md (County) (State)

Injured at home, farm, industry, public place (where?) Public Highway

Means of injury: Auto Accident Injured at work? No

23. SIGNATURE: Deputy Med. Exam Kent Co Md.

Address: Chestertown Md M. D. or other Date signed Oct. 20. 47

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 1a

09146

Reg. Diat. No. 204

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County: Kent

City or town: near Galestown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred: 0

How long in hospital or institution? 2nd

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown R.R. 2 Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. Near Galestown

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Cora Dixon Harris

3. (b) Social Security Number: c

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	col	married

6.(b) Name of husband or wife: Lawrence Harris

6.(c) If alive, give age: 88 years

7. Birth date of deceased (mo., day, yr.): December 23. 1867

8. AGE:

Years	Months	Days	If less than one day
79	11	13	..... hrs. ..... min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Home maker

11. Industry or business:

FATHER — 12. Name: Henry Dixon

FATHER — 13. Birthplace: Rehoboth Del

MOTHER — 14. Maiden name: Emma Chambers

MOTHER — 15. Birthplace: Chestertown

16. Informant: Lawrence Harris

Address: Chestertown

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 18/47 (month) (day) (year)

Cemetery or crematory: Georgetown

Location: Chestertown R.D. Md

18. Funeral director: Asbury Henry

Address: Chestertown Md

19. Oct-18 19 47 (Date rec'd by registrar) F. M. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16/47 19 47, at 7.38 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 42 to ..... 19 .....

and that I last saw her alive on Oct 12 19 47

Immediate cause of death	DURATION
Chronic nephritis	years
Due to: Hemiplegia	1944
Due to: Cerebral sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Grant W. Smith M. D. or other

Address: Chestertown Date signed: 10/16/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

142 b

09147

Reg. Dist. No. 201

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hours

Hospital, institution, or street address where death occurred: Kent and Queen Annes Hosp.

How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: (Rural) Still Pond

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Evelyn Hogans

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Aubrey Hogans

6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): April 1, 1912

8. AGE: Years: 35 Months: 6 Days: 9 If less than one day: hrs. min.

9. Birthplace: Barclay, Queen Anne, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Walter Collier

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Annie Chambers

MOTHER 15. Birthplace: Queen Anne Co., Maryland

16. Informant: Hosp. records

Address: Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 13 1947 (month) (day) (year)

Cemetery or crematory: Chestertown Md

Location: Chestertown Md.

18. Funeral director: B R Fellows

Address: Still Pond Md.

19. Oct 13 1947 (Date rec'd by registrar) J Meloch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10 1947, at 10 15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 10 1947 to Oct. 10 1947 and that I last saw her alive on Oct 10 1947

Immediate cause of death	DURATION
Respiratory failure	
due to anaesthetic shock	
Due to	
Due to	
Other conditions Ruptured ectopic pregnancy	11 hours.

(Include pregnancy within 3 months of death)

Major findings of operations: Ruptured ectopic pregnancy, left tube. Date of op. 10-10-47

Autopsy Results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A C Sick, M.D. M. D. or other

Address: Chestertown, Md Date signed: 10-10-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

09148

CERTIFICATE OF DEATH

Reg. Dist. No. 208

1. PLACE OF DEATH: Kent

County

City or town: Near Massey
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Temporary

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Near Massey
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rurel, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME: Paul Franklin Jester

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ***

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 6, 1923

8. AGE: Years	Months	Days	If less than one day
23 (23)	10	12	..... hrs. ..... min.

9. Birthplace: Denton Md.
(Town, county, and state)

10. Usual occupation: Farm work

11. Industry or business: Farming

FATHER — 12. Name: Edward Jester

13. Birthplace: Denton Md.

MOTHER — 14. Maiden name: Roxy Hamilton

15. Birthplace: Delaware

16. Informant: Edward Jester

Address: Middleton Del

17. (Burial, cremation, or removal. Which?) Date thereof: 10-22-47 (month) (day) (year)

Cemetery or crematory: St Ann

Location: Near Middletown Del.

18. Funeral director: G. Lester Daniels

Address: Middletown Del.

19. Oct. 22 1947 (Date rec'd by registrar) Edward Fellows Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 18, 1947 19..... at 11P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Did not attend Investigated Death 19.....
and that last saw h... alive on ..... 19..... Signed certificate as Deputy Med. Exam
Kent Co Md

Immediate cause of death: Frqcture skull laceration left eye — DURATION

Due to: Lacerations chest and leg — Immediate

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of Oct. 18. 194

Where did injury occur? Near Massey (City or town) Md. (County) (State)

Injured at home, farm, industry, public place (where?): Public highway

Means of injury: Automobile accident — Injured at work? no

23. SIGNATURE: [illegible] M. D. or other

Address: [illegible] Date signed: 10-20-47

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09149

159

Reg. Dist. No. 204

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

Georgetown

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: George town

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Arthur Lee Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Oct 5 1947

8. AGE: Years | Months | Days: 12 | If less than one day: hrs. min.

9. Birthplace: Chestertown Md Kent (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: Arthur Robert Jones

FATHER — 13. Birthplace: Chestertown, Md

MOTHER — 14. Maiden name: Florence Commodore

MOTHER — 15. Birthplace: Chestertown, Md

16. Informant: Arthur R Jones

Address: Chestertown

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Oct 18 47 (month) (day) (year)

Cemetery or crematory: Georgetown

Location: Chestertown R.D. Md

18. Funeral director: Ralph Henry

Address: Chestertown

19. Oct. 18 1947 (Date rec'd by registrar) J H Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17 1947, at 3:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/16 1947, to 10/17 1947 and that I last saw h— alive on 10/16 1947

Immediate cause of death	DURATION
Prematurity	
8 mo - 5½ lbs	
Due to: Urinary retention	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: Albert A Burgard M. D. or other

Address: Rock Hall, Md Date signed: 10/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93a

09150

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: D

3.(a) FULL NAME: Mary Groves Lamb

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Francis D. Lamb

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 19, 1856

8. AGE: Years	Months	Days	If less than one day
90	10	23	hrs. min.

9. Birthplace: Kent County Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John A. Groves
13. Birthplace: Delaware

MOTHER
14. Maiden name: Sarah Schuster
15. Birthplace: Maryland

16. Informant: Mr. Wm. Lamb (son)

Address: Chestertown, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 15, 1947 (month) (day) (year)

Cemetery or crematory: Chester Cem.

Location: Chestertown, Maryland

18. Funeral director: J. Willis Wells

Address: Chestertown, Md.

19. Oct. 14, 1947 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12 1947, at 1.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940, to 19..., and that I last saw her alive on Oct. 12 1947

Immediate cause of death	DURATION
Due to: Age	
Due to: Acute Myocarditis	10 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank H. Smith, M. D., or other

Address: Chestertown Date signed: 12/12/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09151

458

CERTIFICATE OF DEATH

Reg. Dist. No. 701

1. PLACE OF DEATH:

County: Kent

City or town: Still Pond md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred: —

How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Still Pond md

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mr. Charles H Medders.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single.

6.(b) Name of husband or wife: —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Oct 21 1869

8. AGE:

Years	Months	Days	If less than one day
77	11	16	..... hrs. ..... min.

9. Birthplace: Kent Co md.

(Town, county, and state)

10. Usual occupation: Doctor.

11. Industry or business: Doctor.

FATHER

12. Name: Albert Meddes

13. Birthplace: Kent Co md

MOTHER

14. Maiden name: Virginia Boyd

15. Birthplace: Fredrick md.

16. Informant: Mrs Meddes

Address: Still Pond md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 8. 1947 (month) (day) (year)

Cemetery or crematory: Still Pond

Location: Still Pond md

18. Funeral director: B R Wallows

Address: Still Pond md

19. Oct 8 1947 (Date rec'd by registrar) J M Clark Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 6 1947, at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1st 1947, to Oct 6th 1947

and that I last saw h alive on Oct 6th 1947

Immediate cause of death	DURATION
Hemorrhage of Carotid artery.	
Due to	
Due to	
Other conditions: Cancer of throat & Tongue	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: L. P. Atwell M. D. or other

Address: Still Pond Date signed: 10-8-47

VS A15 9.45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d B 09152

Reg. Diat. No. 201

1. PLACE OF DEATH:

County: Kent

City or town: Kent Moss Park: Kennedyville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Summer home

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pennsylvania County: Delaware

City or town: Drexel Hill Pa

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4027 Garrett Road

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Earl Ruby Shultz

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Janette Clark

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): December 15 1897

8. AGE: Years: 49 Months: 9 Days: 27 If less than one day: ... hrs. ... min.

9. Birthplace: York Pa (Town, county, and state)

10. Usual occupation: Barber

11. Industry or business:

FATHER — 12. Name: John H. Shultz

13. Birthplace: York Co Pa

MOTHER — 14. Maiden name: Wilhelmina Ehseling

15. Birthplace: York Co. Pa

18. Informant: Mrs Janette Shultz

Address: 4027 Garrett Road Drexel Hill

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 16 1947 (month) (day) (year)

Cemetery or ~~crematory~~: Arlington

Location: Drexel Hill Pa.

18. Funeral director: Edgar Fellows

Address: Millington Md.

19. Oct 14 1947 (Date rec'd by registrar) J. H. Kelsick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12 1947, at 2.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death: Sudden death — DURATION

No Medical Service

Due to:

Due to: Acute Myocarditis

Other conditions: Coronary Thrombosis

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank W. Smith M. D. or other

Address: Chestertown Md Date signed: Oct 15/47

Medical Examiner

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 922

09153

CERTIFICATE OF DEATH

Reg. Diat. No. 203

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, Institution, or street address where death occurred: —

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall.

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Harriett Ann Simmons

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: Isaac N. Simmons

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 21 - 1855

8. AGE:

Years	Months	Days	If less than one day
92	8	10	..... hrs. ..... min.

9. Birthplace: Kent Co. Md. (Town, county, and state)

10. Usual occupation: Home work

11. Industry or business

FATHER — 12. Name: Benjamin Pearce

13. Birthplace: Unknown

MOTHER — 14. Maiden name: —

15. Birthplace: —

16. Informant: Mrs Emma Jaquette Langton

Address: Rock Hall.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 2. 47 (month) (day) (year)

Cemetery or crematory: Chestertown

Location: Chestertown Md.

18. Funeral director: Edgar L. Lane

Address: Church Hill Md.

19. 11/2 19 47 (Date rec'd by registrar) J. Elwood Burgess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 31 19 47, at 5 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1940, to October 19 47

and that I last saw h— alive on October 31 1947

	DURATION
Immediate cause of death: Cerebral Thrombosis	5 days
Due to:	
Due to: Arteriosclerosis	1940
Other conditions: Arthritis deformans	1942

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frances Smith M. D. or other

Address: Chestertown Md. Date signed Nov. 1/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

09154

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 79 years
Hospital, Institution, or street address where death occurred: 108 N. Queen Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 108 N. Queen Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nannie Brice Skipper

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Thomas Herbert Skipper
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 6, 1868

8. AGE:

Years	Months	Days	If less than one day
79	0	22	..... hrs. ..... min.

9. Birthplace: Kent County, Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John Brice
13. Birthplace: Kent County, Md

MOTHER
14. Maiden name: Anne Elizabeth Ford
15. Birthplace: Kent County

16. Informant: Miss Harriette Welch
Address: Chestertown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 30, 1947 (month) (day) (year)
Cemetery or ~~crematory~~: Chest...
Location: Chestertown, Maryland
18. Funeral director: Marion V. Williams
Address: Chestertown Maryland

19. Oct. 30, 1947 (Date rec'd by registrar) Chas. L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28 1947 at 10:55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 30 1947 to Oct. 28 1947
and that I last saw her alive on October 28 1947

Immediate cause of death	DURATION
Generalized circulatory failure	5 days
Due to Chronic myocarditis	12 years
Due to Hypertensive cardio-vascular heart disease	15 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A. E. Sick, M. D. (M. D. or other)
Address: Chestertown, Md. Date signed: 10-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

09155

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 128

CERTIFICATE OF DEATH

Reg. Dist. No. 2 0 0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Kent
City or town: Galena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred: Galena
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Galena
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Helen D Spry

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: (Late) Irwin W Spry
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 14 1886

8. AGE: Years	Months	Days	If less than one day
61	5	1	..... hrs. ..... min.

8. Birthplace: Galena Kent Co. Md
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: home

FATHER
12. Name: James D. Davis
13. Birthplace: Sussex Co. Delaware

MOTHER
14. Maiden name: Josephine A. Statts
15. Birthplace: Kent Co. Maryland

18. Informant: Mrs John B. Walls (daughter)
Address: Galena, Kent Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof oct. 19 1947 (month) (day) (year)
Cemetery or crematory: Forest
Location: Middletown Delaware

18. Funeral director: Marion H. Williams
Address: Chestertown, Maryland

19. Oct. 18 1947 (Date rec'd by registrar) Elizabeth J. Mumford Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 15 1947, at 6:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 28 1947, to Oct 15 1947
and that I last saw h.. alive on Oct 15 1947

Immediate cause of death	DURATION
Acute pancreatitis and hepatitis	2 days
Due to	
Due to	
Other conditions: Chronic & acute Cholecystitis	3 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Theodore F Paprocki MD
M. D. or other
Address: Galena Md Date signed 10-15-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09156

CERTIFICATE OF DEATH

Reg. Dist. No. 204

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown R.F.D. # 2 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Kent

City or town: Chestertown (If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. # 2 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lottie Jane STOKES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Walter Herbert Stokes

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): October 12, 1893

8. AGE: Years	Months	Days	If less than one day
53	11	27	hrs. min.

9. Birthplace: Kent Co. Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Alonza P. Foreman

13. Birthplace: Maryland

MOTHER 14. Maiden name: Martha Hurd

15. Birthplace: Maryland

16. Informant: Mr. Walter Herbert Stokes

Address: Chestertown, Md. R.F.D. #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 12. 1947 (month) (day) (year)

Cemetery or crematory: Chester Cemetery

Location: Chestertown, Maryland

18. Funeral director: J. Willis Wells

Address: Chestertown Maryland

19. Oct-10 1947 (Date rec'd by registrar) D. H. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 - 9 1947, at 12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1947, to 10 - 8 - 1947 and that I last saw h alive on 10 - 8 1947

Immediate cause of death: Apoplexy — DURATION

Due to: H B P

Due to:

Other conditions: Organic heart trouble

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H P Copeland M.D. or other

Address: Chestertown Md. Date signed: 10-9-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

09157

Reg. Dist. No. 202

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 209 N. Front St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Walk In

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Hannah Maslin Wilton

3.(b) Social Security Number:

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: married

9.(b) Name of husband or wife: William B. Wilton

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): July 20 1879

8. AGE: Years: 68 Months: 3 Days: 3 If less than one day: hrs. min.

9. Birthplace: Kent Co. Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: home

FATHER

12. Name: John Carville Maslin

13. Birthplace: Kent Co. Maryland

MOTHER

14. Maiden name: Hannah Ball

15. Birthplace: Bear, Delaware

19. Informant: Mr. William B. Wilton (Husband)

Address: Chestertown Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 25, 1947 (month) (day) (year)

Cemetery or crematory: Chestertown

Location: Chestertown Maryland

19. Funeral director: Manning & Williams

Address: Chestertown Maryland

19. Oct. 25, 1947 (Date rec'd by registrar) Chas. L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 23 1947, at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to Oct 23 1947 and that I last saw him alive on Oct 20 1947

Immediate cause of death: Coronary Thrombosis — DURATION: One Day

Due to: Hypertensive Heart Disease — DURATION: years

Due to: Myocarditis — DURATION: years

Other conditions: — DURATION: months

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: David Thomas M.D.

Address: Easton Md. M. D. or other

Date signed: Oct 24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09158

Reg. Dist. No. 201

1. PLACE OF DEATH:

County: Kent Co

City or town: Kennedyville md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years.

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Kennedyville Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME: William Heston Wiltbanks

3.(b) Social Security Number: 213-74-1164.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Feb 19 1927

8. AGE: Years: 20 | Months: 7 | Days: 29 | If less than one day: ... hrs. ... min.

9. Birthplace: Kennedyville Kent Co md. (Town, county, and state)

10. Usual occupation: Farm work

11. Industry or business: Farm

FATHER — 12. Name: Heston Wiltbanks

FATHER — 13. Birthplace: Kent Co md.

MOTHER — 14. Maiden name: Liddie Dixon

MOTHER — 15. Birthplace: Queen Annes Co md.

16. Informant: Heston Wiltbanks

Address: Kennedyville md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 22 47 (month) (day) (year)

Cemetery or crematory: Galena

Location: Galena md

18. Funeral director: C.R. Tolbert

Address: Still Pond md

19. Oct 22 1947 (Date rec'd by registrar) J.M. Elliott Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 18 1947, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 15-47 1947 to Oct 18-47 1947 and that I last saw h... alive on Oct 18-47 1947

Immediate cause of death	DURATION
Tuberculosis of Lungs	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: A.B. Copeland M. D. or other

Address: Chesterlaine Date signed: Oct 20 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15